Articles

Health Care for the Indigent: Overview of Critical Issues

Gloria J. Bazzoli

Health care for the indigent is a major problem in the United States. This review of the literature on health care for the indigent was undertaken to determine which major questions remain unresolved. Overall, this article finds that a very large pool of individuals under age 65 are at risk of being medically indigent. A myriad of health programs for some economically disadvantaged individuals do exist, but their level of funding has fluctuated over time—and many poor individuals must rely entirely on the generosity of a relatively small number of hospitals and other providers for their care. Economic pressures on these providers as well as structural changes in the health care sector can only adversely affect the amount of charity care that they offer. It is clear that a well-planned solution to indigent care in the United States, rather than a piecemeal approach, is needed.

Health care for the indigent is quickly becoming an area of critical concern. Competition in health care and the cost-containment efforts of third-party payers and private businesses have created financial pressures on health care providers, which may be leading them to reduce the amount of charity care they offer. In addition, the Reagan administration and several state governments have sought ways to contain public expenditures on health programs for the disadvantaged in the past few years, even as the number of individuals requiring charity care has increased.

The purpose of this article is to review the literature on health care for the indigent in an effort to determine the major questions that

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The author is a partner in Health Policy Research Group, Chicago. Address correspondence and requests for reprints to Gloria J. Bazzoli, Ph.D., Health Policy Research Group, P.O. Box 46274, Chicago, IL 60646.

remain unresolved. The review focuses on those issues that need to be addressed in order to understand the indigent problem:

- How many individuals are medically indigent, and how do they differ from the rest of the population?
- What kinds of public programs exist to provide assistance to the economically disadvantaged?
- Who provides health services to individuals who are unable to afford their own care?
- How will structural change in the health care system affect indigent care?

An analysis of these different issues is complicated by the problem of identifying individuals who are medically indigent. Studies examining the characteristics of the medically needy tend to focus on those who lack, or have inadequate, health insurance coverage. These groups most definitely are at risk of becoming medically indigent if they experience a costly illness, but it is not known how many of them experience difficulties obtaining or paying for their care at any particular point in time. Health care providers, unfortunately, cannot eliminate these gaps in our knowledge. The information they report on the amount of uncompensated care they provide has two problems. First, uncompensated care equals the sum of charity care plus bad debt; the former is clearly associated with care of the indigent while the latter may not be. In addition, health care providers have no information on the number of individuals who need care but who because of their indigency do not seek or obtain it. Thus, measuring the extent of medical indigency in the United States, given current available information, is no simple task.

Another source of confusion is the general lack of understanding of Medicaid's role in providing for care to the economically disadvantaged. Since Medicaid is a large program, many in the public believe that it has eliminated the problem of access to care for the poor. However, the federal government requires that states cover only selected categories of poor individuals to obtain matching federal funds. In particular, states must cover recipients of Aid to Families with Dependent Children (AFDC), who are single parents with dependent children and whose family income typically is less than 75 percent of the federal poverty level, and SSI recipients, who are aged, blind, or disabled individuals with income less than the poverty level. This leaves other groups of poor individuals—notably, intact families, single

adults, and childless couples—ineligible for Medicaid even if they are in need of care and cannot afford it.

Overall, this review of the existing literature suggests that indigent care is a major problem in the United States, requiring a well-planned rather than piecemeal solution. Around 45.3 million individuals under age 65 are at risk of being medically indigent. Of these, approximately 56 percent are particularly vulnerable due to their low incomes. A myriad of health programs exist for the poor, but their level of funding has fluctuated over time. To a large extent, these programs have financed providers for indigent care. However, many individuals who are in need must rely on the generosity of a relatively small number of hospitals and other providers. The economic pressures on these providers as well as structural changes occurring in the health sector can only have an adverse effect on the amount of charity that they can offer.

The following sections explore the findings of earlier research. The first section reviews estimates of the size and distinguishing characteristics of the indigent population. The second describes the federal, state, and local programs developed to address the indigent care problem. Information on the extent of charity care and the characteristics of large providers is reported in the section that follows. And the final section explores the potential effects of the changing health care system on indigent care.

PROFILE OF THE MEDICALLY INDIGENT POPULATION

An examination of the size and characteristics of the medically indigent population is a necessary first step toward understanding the nature of the indigent care problem in the United States. However, identification of the indigent population is difficult due to problems associated with collecting needed data. Individuals simply asked about their ability to pay for health care provide subjective self-assessments of their situations. Health care providers asked about the number of indigents they treat may include inappropriate groups, such as some individuals who can afford care but do not pay their bills. Providers also have no way of knowing about individuals who need care but who, because of their indigency, do not seek it. In addition to describing the methods used by prior researchers in their attempts to distinguish the indigent population, this section will discuss the shortcomings of those methods.

ESTIMATES OF THE SIZE OF THE INDIGENT POOL

The literature has developed several proxy definitions of medical indigency. By far the most frequently used is lack of public or private health insurance coverage. The rationale behind this definition is that the uninsured are entirely responsible for their own medical expenses. If they experience a costly illness, they are less likely to be able to afford necessary treatment than similarly ill individuals with insurance coverage.

Table 1 presents estimates of the proportion and number of individuals under age 65 who are uninsured for different years between 1977 and 1982.[1] These estimates were all obtained from cross-sectional survey data and thus reflect estimates of the publicly and privately uninsured at a single point in time for the year in question. The figures for Kasper, Walden, and Wilensky (1980) [1] are based on the first wave of the National Medical Care Expenditure Survey, which tracked households throughout 1977.[2] Similarly, the figures for the U.S. Bureau of the Census [3] represent the first wave of a continuing survey. Farley [4], who used data from the former survey for the entire year, found that 9.0 percent of the population under age 65 (17.1 million) were uninsured *all* year, and 9.4 (17.8 million) were uninsured *part* of the year, for a total of 18.4 percent (34.9 million) uninsured at some time during 1977.

Clearly, there is substantial variation in the estimated uninsured

Table 1: Estimated Size of the Uninsured Population in the United States Under Age 65

Study	*Year of Estimate*	*Percent of Population Uninsured*	*Estimated Number of Uninsured (Millions)*
Kasper, Walden and Wilensky [1]*	1977	13.6%	25.7
Swartz [5]	1981	15.2	30.7
	1982	16.5	32.7
Robert Wood Johnson [6]*	1982	9.6	19.3
Health Insurance Association of America [7]	1982	5.1–7.7	10–15
U.S. Bureau of the Census [3]	1983	17.0	34.4

*Computed from data in study, which included population 65 or over.

population, even for the same year. These variations arise primarily because of the different types of data used to generate estimates. The first three studies in Table 1 [1,5,6] and Farley [4] use household survey data, which overestimate the number of uninsured to some extent since individuals tend to underreport insurance coverage [7]. The data used in the 1984 estimate by the Health Insurance Association of America (HIAA) [7], on the other hand, underestimate the number uninsured because they do not adequately control for duplicate coverage. Thus, for 1982, the year with the most estimates in Table 1, an intermediate estimate of 21.5 million is probably a good approximation of the number uninsured at any given point in the year.

The major shortcoming of identifying the indigent by lack of insurance coverage is that individuals with limited health insurance coverage are excluded. Some states limit the number of physician visits and/or hospital inpatient days covered by public Medicaid insurance; once individuals reach these limits, they are basically uncovered. In addition, some individuals with private insurance may have inadequate coverage in that they would have to spend a substantial proportion of their income if they had large health bills. In particular, the Congressional Budget Office [8] reported that 23 percent of non-poor and non-elderly families had out-of-pocket medical expenses of $1,130 in 1982 (5.6 percent of median family income in that year), and 5 percent of families had expenses of over $5,000 (14.9 percent of median family income).[3] The criterion of no insurance, then, ignores the problem of inadequate coverage.

Farley [4] has derived estimates of the number of individuals in the population under age 65 at risk of inadequate coverage under their private insurance. Her definition of underinsurance depends on the probability that an individual will experience large out-of-pocket expenses due to a costly illness. Farley's intermediate estimates suggest that around 8.3 percent (15.8 million) of the population under age 65 in 1977 had inadequate private insurance coverage. If this same proportion were applied to 1982, 16.8 million in that year would be underinsured.

This still underestimates the total extent of inadequate coverage in the under-age-65 population. Farley's definition of underinsurance has thus far been applied only to privately insured individuals.[4] Even if it were to be developed, though, certain subgroups within the indigent population would not be captured by the uninsured and underinsured. Aday, Anderson, and Fleming [10] developed an index for the "medically disadvantaged" that incorporates two of these excluded groups, those who (1) lack a regular source of care because of their financial

situation, or (2) need care but are unable to obtain it. This index, when applied to attitudinal data collected for the Robert Wood Johnson Foundation, indicates that an additional 7 million individuals should be categorized as medically indigent in 1982.[5]

Combining these different figures for those who were uninsured, underinsured, and otherwise medically disadvantaged, around 45.3 million individuals in 1982 (22.4 percent of the population under age 65), were at risk of being unable to afford needed health care. Of course, all of these individuals might not have been experiencing difficulties paying their health bills, but they do represent those who potentially might have become medically needy if illness or a disabling condition had hit them or their families.

CHARACTERISTICS OF THE POPULATION AT RISK OF MEDICAL INDIGENCY

The existing literature has identified certain factors that distinguish the potentially indigent. The most influential factors are:

- family income level
- employment status
- age
- race/ethnicity.

For the most part, studies have been descriptive rather than analytical in examining the characteristics of the indigent population. The findings in these different studies, however, have been fairly consistent.

Family Income

Table 2 reports the distribution of the publicly and privately uninsured population across family income categories for selected years as reported in Swartz [5]. The large proportion of uninsured who fall into the low-income categories is apparent; in each year, about 60 percent of the uninsured had income below 200 percent of the poverty line. The data also show the proportion of uninsured under the poverty line increasing between 1979 and 1982.

Among the underinsured, low family income is also a common characteristic. According to Farley [4], 17.7 percent of the poor and near-poor population are underinsured in contrast to only about 4.3 percent of those with high income. Thus, low-income individuals who obtain private insurance coverage do not necessarily eliminate the risk of becoming indigent. Poorer individuals are more likely to be unable

Table 2: Distribution of Uninsured Across Different Family Income Levels

Income Relative to Poverty Line in Year	*Year*		
	1979	*1981*	*1982*
Less than 100%	28%	33.5%	35%
100-199%	29	30	29
200-299%	19	17	16
300-399%	10	8.5	9
Above 400%	14	11	11

Source: Swartz [5].

to afford comprehensive coverage and/or may work for firms that offer very limited health benefits. Even with comparable coverage, though, a low-income individual may be underinsured since a given uncovered health expense represents a larger portion of his/her income.

Employment Status

Differences in employment status also distinguish the potentially indigent. Full-year-employed individuals and those not in the labor force are more likely to have health insurance coverage than are those under age 65 who have only partial commitments to the labor force. For example, Wilensky and Berk [11] found that 8.7 percent of those employed all year, 12 percent of those employed part-year, and 7.6 percent of those never employed were without health insurance for the entire year. Most firms, especially those with 50 or more workers, offer health insurance to their permanent employees as a fringe benefit,[6] and many of those unattached to the labor force rely on public health insurance. Part-year employees, however, often do not qualify for public coverage because of their earnings and lack the necessary employment stability to obtain employer-provided insurance.

The relationship between unemployment and insurance coverage has received much attention in recent years, since it is feared that the unemployed may lose private coverage and be unable to obtain public coverage. Monheit et al. [13], however, found that in 1977 most unemployed individuals (92 percent) retained private insurance coverage. As documented in Blendon, Altman, and Kilstein [14], Hester [15], and Swartz [5], however, a strong positive relationship between unemployment and lack of insurance coverage was present for 1982. Swartz, for instance, found that the proportion of workers who were unemployed in the general economy rose by 41.7 percent between 1979 and

1982, but the proportion who were unemployed among the pool of uninsured increased by 60.8 percent over this period.

Swartz [5] reconciles the difference between her results, based on data for 1979 to 1982, and those of Monheit et al. [13], which used 1977 data, by the differences in the nature of unemployment in these years. In 1977, the economy was growing and those losing their jobs were mostly secondary workers who were covered by the health insurance of the primary wage earners in their families. In addition, some of the primary workers who were laid off may still have been able to maintain their health insurance coverage through union agreements. In 1982, on the other hand, the economy was in a deep recession. The durable goods and manufacturing sectors, where health insurance is most prevalent, were hardest hit by the recession. Union workers who might have been able to retain coverage during short periods of lay-off most likely lost their coverage over the long recession. Thus, it appears that when there are cyclical downturns in the economy, unemployment is associated with losses in insurance coverage—and that when the economy is strong, as in 1977, this does not occur.

Although this proportion of unemployed who are uninsured is greater than the proportion of employed who are uninsured, the employed uninsured are worth considering. As Monheit et al. [13] points out, in absolute number more individuals are employed and uninsured than are unemployed and uninsured. Several studies have examined how insurance coverage varies across firms and across different types of workers (Malhorta [16], Taylor and Lawson [17], Mellow [18], Swartz [19], Berk and Wilensky [20], and Chollet [21]). In all, these studies have shown that firm size and income level are very important determinants of whether employed individuals are insured. Taylor and Lawson [17] found that 90 percent of the firms that do not offer group health insurance to workers employ under ten workers; these firms accounted for nearly two-thirds of all workers who do not have coverage. In addition, Berk and Wilensky [20] report that 22 percent of workers with annual incomes less than 125 percent of the federal poverty line were without health insurance for the entire year in 1977. Finally, all studies examined have found that health insurance coverage is more likely in some industries, notably manufacturing, than in other industries, such as the service sector.

Among the underinsured, Farley [4] found similar relationships with employment status. The proportion of full-time employees who were underinsured in 1977 was 6.9 percent, as compared to 9.2 percent of part-time workers and 11.0 percent of individuals who did not work in that year.

Table 3: Insurance Status by Age in 1977

Age in Years	*Uninsured All Year*	*Uninsured Part of Year*	*Underinsured*
Less than 19	8.4%	9.0%	5.9%
19-24	13.3	18.4	9.6
25-34	9.0	11.0	7.4
35-54	8.2	6.4	7.8
55-64	7.9	5.5	17.9

Source: Farley [4].

Age

Table 3 reports on the insurance status of individuals in different age groups for 1977 [4]. Several interesting patterns are apparent. First, young adults between 19 and 24 years of age frequently do not have coverage: for 1977, 31.7 percent had no health insurance for either the entire year or at least part of the year. These individuals often are ineligible for coverage offered by employers and are unable to obtain dependent coverage through a parent or guardian. In addition, young adults may not feel the need to purchase health insurance since they typically have good health.

Interesting trends in rates of uninsured and underinsured status are also apparent for ages 25 and over. The proportion uninsured (using Farley's definition) decreases with age, but rates of underinsurance increase. As individuals age, they have increased employment stability so they are more likely to have private insurance. Underinsurance increases, though, because older individuals have larger potential health expenditures.

Swartz [5] finds an additional relationship, not reported in Table 3, between age and insurance coverage. An alarming number of children are uninsured even though they live with insured parents or guardians. Among all uninsured children in 1982, 36.3 percent (4.1 million) lived in households with insured parents or guardians. This proportion has remained relatively stable over time. Thus, a large number of families either cannot afford dependents' health insurance coverage or work for firms that do not offer dependent coverage.

Race/Ethnicity

All studies examined have found that persons of black and Hispanic background are more often uninsured than white individuals (Wilensky and Walden [22], Wilensky and Berk [23], Robert Wood Johnson Foundation [6], and Aday and Anderson [24]). In particular,

Aday and Anderson found that among nonwhites, 14 percent in 1976 and 12 percent in 1982 were uninsured, as compared with 9 percent of whites in 1976 and 8 percent in 1982.

In relation to underinsurance, though, a smaller proportion of minority individuals under age 65 (6.3 percent) is underinsured compared to nonminority individuals (8.7 percent) (Farley [4]). Minorities less frequently have private insurance, and thus, as a group, relatively fewer are at risk of being identified as underinsured, given Farley's definition.

SUMMARY

Although exact identification of the medically indigent population has not been possible given existing data, this section has used data in the available literature to estimate the population at risk of medical indigency. The upper-bound measure of this group is approximately 45.3 million individuals in 1982; 22.4 percent of the population under age 65 falls into these categories at some point during the year. Population groups overrepresented among the potentially indigent include:

- The poor and those with family income just above the poverty line
- Families whose primary earner is unemployed for a long period of time or has only occasional participation in the labor force
- Individuals from racial or ethnic minority groups.

In addition, a large number of young people, even those living with insured parents or guardians, lack health insurance.

Within the 45.3 million at-risk population in 1982, two groups are especially vulnerable to becoming medically indigent: (1) those with limited financial resources, for whom even a simple illness may represent a large financial burden; and (2) individuals who have extensive health care needs. No data are available on the latter, but it is possible to estimate how many in the at-risk population have limited resources. Of the 45.3 million, around 25.4 million (56.1 percent) were poor or near-poor in 1982.[7] Thus, a substantial portion of the at-risk group are highly likely to experience difficulties obtaining or paying for health care if the need arises.

Although these estimates give some idea of the magnitude of the indigent care problem, certain questions remain unresolved and require further study: who are the truly needy (and how does one define true need)? In what ways do they differ from the uninsured and underinsured populations? How many of those in the medically indi-

gent group have immediate need for care? What are the characteristics of those with the most need?

MAJOR PUBLIC PROGRAMS

Federal, state, and local governments have all developed programs that seek to provide or finance health care for the disadvantaged.[8] The major efforts include:

- —Public forms of health insurance that reimburse providers for care rendered to covered individuals
- —Financial support to private institutions providing substantial amounts of indigent care
- —Public clinics, health centers, or hospitals that were created to treat the economically disadvantaged
- —The development of specific private insurance packages for groups who can afford insurance but have trouble obtaining it or who would otherwise be underinsured given their existing private plan.

This section will synthesize the most recently available information on the nature, scope, and effects of these programs. Unfortunately, existing information has serious gaps; data for some programs, especially new ones, are unavailable, and recent changes in other programs are not reflected in published data. Thus, the exact status of programs currently in existence is not known. However, given recent legislation and general trends, it is clear where these programs will be heading in the future in relation to coverage and financing. This will be discussed at the end of the section.

FEDERALLY INITIATED PROGRAMS

Medicaid

The Medicaid[9] program is the largest and most commonly recognized health care program for the disadvantaged. As authorized under Title XIX of the 1965 Social Security Act, Medicaid is a federal-state entitlement program that reimburses hospitals, physicians, and other providers for the health care of program beneficiaries. Federal funding for the program is determined by a matching rate, which varies from state to state depending on per capita income; Table 4 reports matching rates for programs in existence as of 1982, the latest year for which

Table 4: Medicaid Program Characteristics, 1982

	Federal Matching Rates (Percent)	*Number of Medicaid Recipients (Thousands)*	*Ratio of Medicaid Recipients to Poor (Percent)*	*Total Medicaid Payments (Millions)*	*Average Payment Per Recipient*
All States*	—	20,702	—	$30,920	$1,494
Alabama	71.1%	375	24%	352	939
Alaska	50.0	17	37	47	2,765
Arkansas	72.2	222	27	281	1,266
California	50.0	3,594	83	3,854	1,072
Colorado	52.3	140	27	242	1,729
Connecticut	50.0	222	45	433	1,950
Delaware	50.0	52	36	59	1,135
District of Columbia	50.0	143	51	206	1,441
Florida	57.9	498	24	581	1,167
Georgia	66.3	501	31	574	1,146
Hawaii	50.0	113	104	128	1,133
Idaho	65.4	41	18	60	1,463
Illinois	50.0	1,145	58	1,441	1,259
Indiana	56.7	215	25	504	2,344
Iowa	55.4	206	34	289	1,403
Kansas	52.5	165	38	233	1,412
Kentucky	68.0	407	34	403	990
Louisana	66.9	410	31	560	1,366
Maine	70.6	149	53	186	1,248
Maryland	50.0	319	50	501	1,571
Massachusetts	53.6	750	69	1,208	1,611
Michigan	50.0	1,044	72	1,491	1,428

Minnesota	54.4	323	49	809	2,505
Mississippi	77.4	346	33	228	659
Missouri	60.4	375	36	437	1,165
Montana	65.3	49	34	73	1,490
Nebraska	58.1	77	28	141	1,831
Nevada	50.0	31	22	64	2,065
New Hampshire	59.4	49	33	89	1,816
New Jersey	50.0	648	53	878	1,355
New Mexico	67.2	92	25	101	1,098
New York	50.9	2,270	60	5,840	2,573
North Carolina	67.8	388	25	494	1,273
North Dakota	62.1	40	22	67	1,675
Ohio	55.1	918	47	1,299	1,415
Oklahoma	59.9	278	37	374	1,345
Oregon	52.8	115	34	208	1,809
Pennsylvania	56.8	1,156	64	1,714	1,483
Rhode Island	57.8	127	77	202	1,591
South Carolina	71.0	262	30	296	1,130
South Dakota	68.2	36	17	82	2,278
Tennessee	68.5	364	28	454	1,247
Texas	55.8	669	20	1,224	1,830
Utah	68.6	67	21	108	1,612
Vermont	68.6	52	60	78	1,500
Virginia	56.7	362	29	519	1,434
Washington	50.0	218	35	422	1,936
West Virginia	68.0	224	37	128	571
Wisconsin	58.0	445	67	886	1,991
Wyoming	50.0	13	20	21	1,615

*Excludes other U.S. jurisdictions with Medicaid recipients: Guam, Puerto Rico, and Virgin Islands.

published state data on all the characteristics in the table were available.[10] States are not required to develop a Title XIX Medicaid program, but currently all states have one. The most recent program was developed by Arizona in 1981 as a demonstration project on prepaid, managed care.

Title XIX established guidelines for eligibility, only some of which are mandatory. In order to receive federal matching funds, states must cover all individuals receiving cash assistance from Aid to Families with Dependent Children (AFDC), and most individuals receiving Supplemental Security Income (SSI). They may also extend eligibility to certain other groups and still receive federal matching funds. One such group, designated the medically needy, are those whose incomes disqualify them for medical assistance but who have insufficient resources to pay for needed health care. Through this designation, many elderly individuals qualify for Medicaid to finance nursing home care. Some states, in addition, have extended Medicaid eligibility to groups for which no federal matching funds are available. Expenditures resulting from coverage of these individuals are typically referred to as "State-Only" Medicaid expenditures.

Given the flexibility in eligibility criteria, the relative sizes and characteristics of the recipient pool across states are quite different. In particular, the ratio of Medicaid beneficiaries to those individuals in poverty, which is a proxy for the proportion of poor individuals receiving Medicaid, varies dramatically from state to state: the ratio is highest in Hawaii at 104 and lowest in South Dakota at 17. These wide variations result partly because some states focus primarily on extending eligibility to elderly populations in need of long-term care after meeting federal minimum eligibility requirements. Variations also occur because some states have relatively large groups of poor individuals served by health programs other than Medicaid, such as Indian Health Services and Migrant Health Centers.

Besides eligibility standards, states must also comply with certain service guidelines. They must reimburse for a specific set of services, including inpatient and outpatient hospital care, laboratory tests, skilled nursing services, and physician services. As with eligibility guidelines, states are given substantial leeway in covering additional services with federal matching funds. They may, for instance, cover dental care, optometric services, and/or prescription drugs. Each state is free to limit the scope of coverage for both mandatory and optional services; for example, Alabama covers only 12 days of inpatient hospital care per year and Georgia covers only 12 physician visits annually. In addition, the Tax Equity and Fiscal Responsibility Act of 1982 (PL

97-248) permits states to impose nominal copayments for all mandatory and optional services except for a few groups of program beneficiaries (Lohr and Marquis [27]).

Differences in services and eligibility have led to different patterns of expenditures across states. The last two columns of Table 4 report data on total payments (including federal and state funding) and average payments per recipient.[11] New York has the highest total payments, $5,840 million, but Alaska has the largest payment per recipient, $2,765. States offering fewer services, placing more limitations on the scopes of services, and requiring larger copayments clearly will have smaller expenditures per recipient. In addition, states with more restrictive eligibility for elderly individuals in nursing home facilities will have lower payments, since this type of care tends to be quite costly.

There is general agreement among policymakers and those in the health care field that Medicaid, though a large and diverse program across states, has been effective in increasing access to care for poor individuals. Davis, Gold, and Makuc [28] report that virtually all differentials in the number of physicians and preventive services by income level that were present prior to Medicaid have since narrowed. However, Wyszewianski and Donabedian [29] suggest that quality of care differentials may still be present, and Link, Long, and Settle [30] find that quantity differentials have not narrowed as greatly for black Medicaid recipients as they have for white recipients. Thus, while Medicaid has increased access to care, it has clearly not equated access to all levels of care across poor and nonpoor population groups.

Several studies have examined the effectiveness of the Medicaid program in improving the health status of recipients. Granneman and Pauly [31] reviewed many of these evaluation studies and found that Medicaid in general has had little significant impact on health status. However, several studies have found that the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which screens children for particular health conditions, has been very effective. Applied Management Sciences [32] and Keller [33] found that EPSDT participants had lower overall Medicaid expenses than nonparticipants, even after factoring in the cost of the EPSDT program. Currier [34] found that EPSDT participants had lower health abnormality rates.[12]

The federal government has made, and is considering, several other cuts to the Medicaid program. The Omnibus Budget Reconciliation Act (OBRA) of 1981 lowered federal grants to states by up to 4.5 percent for FY 1984 (Lohr and Marquis [27]). In addition, the Reagan

administration has recently proposed changing Medicaid from an open-ended entitlement program to one with a spending ceiling. The Congressional Budget Office [35] reports that the President's budget would limit 1986 payments to $1.3 billion less than 1985 levels. The administration would also give states greater flexibility in defining eligibility criteria and payments to providers. Finally, it would continue incentives to encourage the development of capitated case-managed care programs.

Several states have also made changes to their Medicaid program in recent years. Iglehart [36] reports that 40 states reduced Medicaid spending after the passage of the OBRA of 1981, by restricting eligibility and reducing covered benefits. Most notable were the cuts in California's Medicaid program in which the State-Only medically indigent adults program was almost completely eliminated, with responsibility for the care of these individuals transferred to the counties. However, according to Richards [37] and the National Governor's Association and Intergovernmental Health Policy Project [38], many states are reconsidering these moves in light of burgeoning indigent care problems. A number of states have also established, or are in the process of implementing, case-managed care programs. Arizona developed the first of these programs in 1983. Iglehart [39] reports that California, Oregon, Massachusetts, Michigan, Colorado, Kentucky, and New York have also elected to develop case-management systems.

Another area of concern for both federal and state governments is the growing share of Medicaid funds going to long-term care (National Study Group on State Medicaid Strategies [40]). The Economic Report of the President [41] reports that nationwide, 30.9 percent of Medicaid expenditures in 1983 were spent on nursing home care, up from 23.4 percent in 1972. Although the largest group of Medicaid recipients were eligible through AFDC (67.8 percent), they accounted for only 35.6 percent of total Medicaid spending in 1983. Examination of long-term care financing through Medicaid is crucial at this time since the demand for this type of care will grow dramatically over the next 20 years as the U.S. population ages.

Federal Health Block Grants and Categorical Programs

Besides Title XIX-Medicaid programs, the federal government has an array of other health programs targeted at particular groups of medically disadvantaged individuals. These programs either provide block grants to states for developing particular health programs or they

Table 5: Federal Health Block Grants and Categorical Programs

Program	*Size of Targeted Population (Thousands)*	*Federal Appropriation (Millions)*
Maternal and Child Health Services Block Grant (FY 1984)	n.a.*	$399.0
Preventive Health and Health Services Block Grant (FY 1984)	n.a.	88.2
Primary Care Block Grant (FY 1984)	4,700.0	337.0
Indian Health Service (FY 1984)	931.0	770.4
Migrant Health Centers (FY 1984)	460.0	42.0
Appalachian Health Finish-Up Program (FY 1984)	213.9	5.2
Medical Assistance to Refugees and Cuban/Haitian Entrants (FY 1983)	95.0	125.8

Source: Senate Committee on Finance [42].
*n.a. = not available.

directly support health care centers. The largest of these programs include:

- Maternal and Child Health Services Block Grant
- Preventive Health and Health Services Block Grant
- Primary Care Block Grant
- Indian Health Centers
- Migrant Health Centers
- Appalachian Health Finish-Up Program
- Medical Assistance to Refugees and Cuban/Haitian Entrants.

Some basic data on numbers served and federal appropriations for each program are reported in Table 5.

The Maternal Child Health (MCH) Services Program was designed to provide prenatal, delivery, and postpartum care to women with low incomes who do not qualify for Medicaid. MCH has many

similarities to Medicaid: programs are administered by each state; federal funding is allocated preferentially to areas with lower per capita income; and states must match federal funds. States can only charge women with incomes above the poverty level for services provided. Studies of the effectiveness of MCH show mixed results. Davis and Schoen [43] reported that MCH has been effective at lowering both maternal and infant mortality among low-income population groups. However, Granneman and Pauly [31] suggest that this finding may be the result of sample selection bias. As Harris [44] points out, no consensus exists about the effectiveness of prenatal care in lowering infant mortality.

The Preventive Health and Health Services Block Grant was established through the OBRA of 1981. States and local communities obtain block grants for addressing particular problems in their communities, including hypertension control, rodent control, and certain health education programs.

The Primary Care Block Grant funds community health centers for low-income individuals. These centers are located in both urban and rural communities that have been designated as medically underserved by the Public Health Service. A 1971 study of urban community health centers found that the quality of care available in these centers was comparable to that found in health department clinics and hospital clinics at medical schools (Morehead, Donaldson, and Seravelli [45]). In addition, a more recent study by Goldman and Grossman [46] credited community health centers with declines in infant mortality. The University of North Carolina [47] found that these centers had a substantial effect on access to health care in rural areas.

All of the programs funded by the three block grant programs in Table 5 have been in existence since the 1970s. However, prior to the OBRA of 1981, these programs were all federally administered. With the passage of this act, authority passed to the states and federal expenditure levels were reduced by about 25 percent (American Hospital Association [48]). Davis and Millman [49] note that these changes have placed difficult demands on community health centers in particular.

The Indian Health Service supports health centers in several different states. These centers provide comprehensive health care to both American Indians and Alaskan Natives. No data are currently available on the influence of these health centers on the health status of Native Americans.

The three remaining programs in Table 5 support health centers

and clinics for other target groups as indicated in their titles. The extent of care provided varies from one program to the next; the Appalachian Health Finish-Up Program and Migrant Health Centers offer only limited types of primary care, while the Medical Assistance to Refugees and Cuban/Haitian Entrants program offers comprehensive care. No data are available on the effectiveness of these government-sponsored health centers.

Hill-Burton Free-Care Obligations

The Hospital Survey and Construction Act (Hill-Burton) of 1946 provided federal funds to each state for the construction and modernization of hospitals. Hospitals receiving these funds were required to provide a certain amount of charity care to indigent individuals. Hospitals met their charity-care obligations by providing a full range of services free or at a reduced rate to eligible individuals. These obligations lasted generally for 20 years. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research [50] reported that charity care requirements were not very stringent until 1979.[13]

Federal funds are no longer available to finance hospital construction and renovation. The Senate Committee on Finance [41] estimated, however, that approximately 3,000 hospitals in 1984 were still fulfilling Hill-Burton charity care obligations. These hospitals provided approximately $3 billion in charity care in that year.[14]

STATE-INITIATED PROGRAMS

Several states have acted independently to resolve indigent care problems in their jurisdictions. In 1984, the Intergovernmental Health Policy Project (IHPP) at George Washington University surveyed states on their indigent care activities. These data form the basis of this subsection. However, it is important to realize that a number of state programs could have been missed by the project due to gaps in data reporting by individual states. In addition, state programs are currently in flux; the National Conference of State Legislatures reports that 88 bills related to indigent care will be considered by state legislatures in 1986.[15] Thus, these programs should be tracked over time.

State/County-Funded Health Services Programs

All states in the United States have programs that reimburse health providers for health care rendered to certain Medicaid-ineligible popu-

lation groups. Many of these state programs are very similar to Medicaid, offering for the most part basic inpatient and outpatient hospital care, physician services, and x-ray and laboratory services. State programs with these characteristics are listed in Table 6. Each program targets a specific indigent group for which federal Medicaid funds are unavailable—typically, state general assistance recipients. Some of these programs are administered by the state's Title XIX-Medicaid office and thus represent State-Only Medicaid programs, which were mentioned briefly in the last subsection. Others, on the other hand, are run by state or county general assistance offices.[16]

Funding for these programs generally comes jointly from states and counties. However, some states mandate their counties to administer and fund their own programs. States in this instance typically offer little, if any, guidance on eligibility or service requirements.

Besides the programs listed in Table 6, a variety of other state/county-funded programs exist that are much more limited in scope. These programs frequently target a specific group of indigents with fairly particular health needs (i.e., high-risk pregnant women, individuals with vision problems, hemophiliacs). Table 7 lists the characteristics of these kinds of programs.[17]

Unfortunately, reliable data on the number of recipients served by the programs listed in Tables 6 and 7 are unavailable. Nor does information exist on the health effects of these programs. Individual states and counties do appear to be quite active in providing assistance to indigent individuals in their jurisdictions. Brown and Cousineau [53], however, have examined whether state mandates for county health programs have been effective. They found that all counties complied only when monitored by state agencies. Thus, if left entirely on their own, county programs may not be providing needed care to area residents.

Financial Support for Hospitals

Rather than targeting indigent individuals, some state programs target hospitals providing substantial amounts of indigent care. These programs give some financial support to such institutions to partially defray their uncompensated care costs. State programs of this type rely on (1) tax-generated indigent care fund pools, (2) all-payer hospital rate-setting programs, and (3) direct financial support of public hospitals and clinics.

For the first, states use their taxing authority to collect and distribute tax-generated revenues to private hospitals on the basis of the

Table 6: State Health Care Programs with Coverage Similar to Medicaid, 1983

State	*Indigent Target Population*	*Source of Funds*	*Program Expenditures FY 1983 (Millions)*
Alabama*	Acutely ill or injured; varies by county	County	–
Alaska	General relief recipients	State	$ 8.7
Arizona†	General assistance recipients	State/County	–
California†	Varies by county	State/County	475.9‡
Colorado	Income up to 230% of poverty line; unable to afford care	State	33.3
Connecticut†	General assistance recipients; medically needy	State/Municipalities	14.7
Delaware*	Varies by county	County	–
Florida*	Varies by county	County	–
Georgia*	Varies by county	County	–
Hawaii	General assistance recipients; medically needy	State	27.5
Idaho*	Varies by county	County	–
Illinois§¹	Ineligible for general assistance; varies by county	State/County	134.6
Indiana*	Low income based on AFDCI standards	County	–
Iowa§	Varies by county	State	24.7‡
Kansas	General assistance recipients	State	25.9
Kentucky*	Varies by county	County	–
Louisiana	Low income	State	–
Maine†	General assistance recipients	State/Municipalities	.4
Maryland	General assistance recipients; Title XIX ineligible; spouses and parents living with Medicaid-eligible person; indigent adults	State	92.5
Massachusetts	General relief recipients	State	7.2
Michigan§¹	General assistance recipients	State/County	67.7
Minnesota†	General assistance recipients; medically needy	State/County	32.2
Mississippi	Varies by participating hospital	State	2.3

Continued

Table 6: Continued

State	Indigent Target Population	Source of Funds	Program Expenditures FY 1983 (Millions)
Missouri	General relief recipients	State	14.7
Montana§	General relief recipients	State/County	4.4
New Hampshire*	Varies by county	County	—
New Jersey§'	Low income	State/County	21.6
New Mexico*'	Aged, blind, or disabled, unable to afford care	State/County	—
New York†	Home relief recipients; medically needy	State/County	533.5
North Carolina*	Varies by county	County	—
North Dakota*	Varies by county	County	—
Ohio†	General relief recipients	State/County	130.7
Oklahoma	Varies by county	County	—
Oregon	General assistance recipients; aged, blind, or disabled	State	13.6
Pennsylvania	General assistance recipients; medically needy	State	356.6
Rhode Island§	General assistance recipients; low-income families with dependent children	State	10.2
South Carolina*	Varies by county	County	—
South Dakota*	Varies by county	County	—
Tennessee*	Varies by county	County	—
Texas*	Varies by county	County	—
Utah§'	Unable to afford care	State/County	2.9
Vermont	General assistance recipients	State	—
Virginia‡ §	Varies by city/county	State/County	8.9
Washington'	General assistance recipients; medically needy	State	50.9
West Virginia*	Varies by county	County	—
Wisconsin	General relief recipients	State/County	2.5‡
Wyoming	General assistance recipients	State	4.2

Source: Desonia and King [52].

*State mandates counties to develop and administer their own indigent care program.

†State mandates counties to participate in the state's program(s).

‡State expenditures only.

§Counties have option to develop and administer own program or participate in state program(s).

'Combination of more than one program.

Table 7: Limited Care Programs for Indigents by State, 1983

State	*Indigent Target Population*	*Services*	*Sources of Funds*	*Program Expenditures (Millions)*
Alabama*	Women	Cancer screening	County	$0.4
Arkansas	High-risk pregnant women	All obstetrical care	State	—
Colorado	Pregnant women	Inpatient obstetrical care	State	1.8
Connecticut	Veterans	All health care	State	3.1
Florida	Women and children including Medicaid-eligible	Prenatal care; inpatient and screening services	State	—
Maine	Low-income with eye disorders	Vision care	State	0.3
Maine	Low-income aged	Prescription drugs	State	1.4
Maryland	Low-income	Prescription drugs	State	3.5
Michigan	Migrant laborers	Hospital care	State	0.3
Missouri	Low-income with eye disorders	Vision care	State	1.0
Missouri	High-risk pregnant women; children	Obstetrical and selected child care	State	5.0
New Jersey	Low-income aged and disabled	Prescription drugs	State	57.0
South Carolina	Low-income with sickle cell anemia	Clinic and some hospital care	State	0.1
Tennessee	Children with speech or hearing problems	Hearing tests; hearing aids	State	—
Tennessee	Hemophiliacs	Blood products; hospital/dental care	State	0.5
Tennessee	Individuals with renal disease	Hospital, physician, and dialysis care	State	1.1
Wisconsin	Individuals with renal disease	Hospital and physician care	State	—
Wisconsin	Hemophiliacs	Home blood products	State	—
Wisconsin	Native Americans	All Medicaid	State	1.8

Source: Desonia and King, [52].

*State mandates county to develop and administer program.

amount of uncompensated care they provide. Florida and New York fund these pools through a surcharge on hospital revenues. Recently enacted programs in Nevada and Oklahoma fund indigent care pools through property taxes (Richards [37] and Desonia and King [52]). The National Governor's Association and Intergovernmental Health Policy Project [38] reports that indigent care task forces in Arkansas and Ohio are recommending the establishment of indigent care pools as well: the Arkansas task force recommending tax assessments on smoking and gambling, and Ohio recommending surcharges on hospitals providing less than required amounts of indigent care.

All-payer rate systems are also used to generate additional funds for hospitals providing large shares of uncompensated care. Maryland, Massachusetts, and New Jersey rate-setting authorities set higher rates for hospitals with large amounts of charity care and bad debt. In essence, these higher rates shift some of the burden of uncompensated care to insurers and self-paying patients of the hospital. Several other states (Connecticut, Maine, New York, West Virginia, and Wisconsin) currently have rate regulation but have different and limited provisions for financing uncompensated care. Myer [54] describes in detail these different provisions.

Alternatively, states directly fund the operation of public hospitals and clinics. In 1982, there were 1,715 public hospitals in this country, supported by a combination of state, county, and municipal funds.

Mulstein [55] suggests that each of these methods for providing funds to large providers of uncompensated care has problems. She notes that public hospitals by their mere presence may lead to segmented care for indigents if other providers view these institutions as the primary or sole source of indigent care. All-payer systems and revenue pools, on the other hand, encourage a wider distribution of indigent patients since they lower the costs of uncompensated care. However, Mulstein concludes that these systems offer little incentive for the efficient collection of debts or management of patient care.

State Insurance Activities

States have also passed insurance legislation designed to increase the availability of insurance coverage to state residents. The aim of these programs is to ensure that individuals and families with average income have adequate insurance to cover large, unanticipated medical expenses. Thus, these programs seek to eliminate or reduce underinsurance. Insurance actions taken by states include:

- Providing catastrophic health insurance coverage (Alaska, Maine, Minnesota, and Rhode Island)
- Requiring insurers to participate in insurance pools that make coverage available to individuals of high medical risk who are unable to otherwise obtain insurance (Connecticut, Florida, Indiana, Minnesota, North Dakota, Rhode Island, and Wisconsin)[18]
- Setting minimum standards for insurance plans offered in the state, typically by specifying that certain types of health services must be covered (Hawaii)
- Requiring insurers to extend group health coverage to workers leaving a firm.[19]

Mulstein [55] notes that a major problem with these activities is that they increase insurers' costs and, thereby, health insurance premiums. As such, these state insurance activities may inadvertently reduce the number of people who can afford adequate insurance coverage.

Other State Activities

Data from the IHPP Survey suggest that states have taken various other actions to deal with the problem of indigent care. For instance, California and South Carolina only approve certificate-of-need applications if hospitals promise to provide certain minimum amounts of charity care. Georgia requires parties purchasing or leasing a public hospital to provide at least 3 percent of hospital gross revenues in indigent care. A variety of other options are under study. The Hospital Research Foundation, for example, has suggested that Pennsylvania consider a mix of government appropriations, earmarked "sin taxes," and in-kind provider services to fund hospital uncompensated care [57]. In addition, 25 states have task forces that have or will be studying and recommending solutions to their indigent care problems: Alabama, Arkansas, Colorado, Florida, Georgia, Indiana, Kentucky, Maryland, Mississippi, Missouri, Nebraska, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

LOCAL INITIATIVES

Many counties and cities have also developed their own independent indigent care programs. No national survey of these programs has taken place. An example of these programs, however, is the Quality

Charity Care Trust in Louisville, Kentucky, in which the city and Humana, Inc. established a trust fund that reimburses Humana for health care provided to the medically needy [52]. Another program was sponsored by the city of Detroit and local hospital agencies during the 1982 recession. This program sought the cooperation of local physicians, hospitals, and other providers to offer free or reduced-fee care to the area's unemployed [48].

SUMMARY

This section has demonstrated that the public sector is aware of the indigent care problem and is responding to it. Various programs have been established that cover the costs of care to particular indigent individuals, that offer some financial support to hospitals rendering large amounts of charity care, and that reduce the number of persons who are uninsured or underinsured by increasing the availability of private insurance coverage. Public funding for these programs has tended to fluctuate over time; thus, so has the number of individuals served.

An important question is what the future holds for these programs. Given large budget deficits and the general philosophy of the Reagan administration, the federal government clearly will continue to seek reductions in spending on Medicaid and the block grant programs. Many states appear ready to increase their financial support, but these increases will probably only be large enough to match the loss of federal funding to those states. Thus, the number of indigents served by public programs is not likely to increase over time.

PROVIDERS OF HEALTH CARE TO THE ECONOMICALLY DISADVANTAGED

Needy individuals seek care from a variety of sources. To a large extent, the programs described in the previous section finance providers for this care. However, many individuals who are in need must rely on the generosity of hospitals and other providers. This section will review the literature on the extent and source of care utilized by the indigent, and on the distribution of care across different providers.

PROFILE OF HEALTH CARE UTILIZED BY INDIGENTS

The health care needs and utilization of the indigent population are difficult to identify since, as indicated earlier, indigents themselves

cannot be easily distinguished. However, many studies have examined needs and utilization patterns of the uninsured. In particular, Sloan, Valvona, and Mullner [58] give some idea of the care sought from hospitals by the disadvantaged. They report that 53 percent of hospital self-pay or charity cases in one state were either maternity or accident cases. An additional 17 percent had digestive disorders, mental disorders, or complicated pregnancies.

A number of studies have examined patterns of health care utilization of the uninsured. Skinner et al. [59] found that the uninsured in one urban area relied on hospital emergency rooms and outpatient clinics for the bulk of their health care. However, statewide studies of Colorado, North Carolina, and Tennessee, all of which included large rural areas, found that the usual source of care for the uninsured was typically physicians [47,60,61]. In addition, Wilensky and Berk [23] report that the poor and near-poor uninsured rely on free hospital care twice as often as those on Medicaid and on free physician care about four times as often. All studies have found that the uninsured have lower rates of hospital and physician utilization, and that utilization of hospital emergency rooms, outpatient departments, and clinics is higher [23,24,62]. Finally, Aday and Anderson [24] found that those without insurance receive substantially fewer basic diagnostic medical procedures—blood pressure readings, pap smears, and breast examinations.

Although the indigent receive fewer services, the total amount of uncompensated care is substantial. Sloan, Valvona, and Mullner [58] report that in 1982, community hospitals had $6.2 billion in uncompensated care, of which $1.7 billion resulted from charity care and $4.5 billion from bad debts. The vast majority of the bad debt amount (68 percent) was due to uninsured patients. Physicians, on the other hand, rendered about $2.9 billion in free or reduced-fee care to unemployed individuals or those who lost Medicaid coverage in 1982.[20]

DISTRIBUTION OF INDIGENT CARE ACROSS PROVIDERS

Hospitals

Uncompensated care in hospitals tends to be highly concentrated. Table 8 reports the distribution of hospital care to the poor using data collected through a major study conducted by the Urban Institute and the American Hospital Association. These data indicate that public hospitals, teaching hospitals (especially Council of Teaching Hospital (COTH) members), and urban hospitals provide a disproportionately

Table 8: Distribution of Hospital Care to the Poor by Selected Hospital Characteristics, 1980 (Percentage Distribution in Parentheses)

Type of Hospital	*Number of Beds (Thousands)*	*Uncompensated Care ($ million)*		*Medicaid Care (Millions)*
		Charity Care	*Bad Debts*	
All Hospitals	972 (100%)	$1,848.8 (100%)	$3,494.3 (100%)	$9,045.1 (100%)
Ownership				
Public	207 (21.3)	1,024.8 (55.4)	1,266.5 (36.2)	2,072.0 (22.9)
Private nonprofit	678 (69.8)	815.8 (44.1)	1,919.1 (54.9)	6,331.8 (70.0)
Proprietary	87 (8.9)	9.2 (0.5)	308.6 (8.8)	641.3 (7.1)
Teaching Status				
Nonteaching	583 (60.0)	386.9 (20.9)	1,579.4 (45.2)	3,675.1 (40.6)
Teaching (Non-COTH)	211 (21.7)	488.4 (26.4)	864.7 (24.7)	2,252.1 (19.4)
Teaching (COTH)	178 (18.3)	974.6 (52.7)	1,050.1 (30.1)	3,117.8 (34.5)
Community Size				
100 largest cities	336 (34.6)	1,163.2 (62.9)	1,689.1 (48.3)	4,892.5 (54.1)
Other SMSA*	384 (39.6)	531.2 (28.7)	1,214.6 (34.3)	3,047.8 (33.7)
Non-SMSA	251 (25.8)	155.4 (8.4)	590.6 (16.9)	1,104.7 (12.2)

Source: Feder and Hadley [68,69].
*Includes suburban areas of the 100 largest cities.

large share of uncompensated care relative to their share of total beds. In addition to the data reported in Table 8, The Commonwealth Fund [67] reported that public teaching hospitals have the highest relative burden of uncompensated care when compared to other teaching hospitals: public teaching hospitals treat only 11 percent of the total volume of care in the United States, but 31 percent of total uncompensated care.

Differences in admission policies explain to some extent these disparities in shares of care. COTH teaching hospitals and public hospitals are in many instances expected to provide substantial amounts of charity care, since they receive state and local government subsidies. Teaching hospitals also view charity care as a means of obtaining needed educational experience for individuals training in the health professions (Fine et al. [70]). Other types of hospitals, specifically private nonprofit, proprietary, and/or non-teaching hospitals, lack these financial and educational motivations.

Two other important findings can be drawn from Table 8. First, Medicaid coverage greatly improves a poor individual's access to care, especially to private nonprofit and proprietary hospitals. Second, Feder and Hadley [68] point out that given the geographical distribution of the poor, the 100 largest cities provide a disproportionately larger amount of indigent care to the urban poor relative to the amount of care given by non-SMSA hospitals to the rural poor.

In an examination of the amount and distribution of charity care over time, Feder, Hadley, and Mullner [71] report that the volume of charity care and its distribution did not change between 1980 and 1982. However, over this period, the number of individuals with incomes below the poverty line increased and the proportion of poor individuals covered by Medicaid declined. Free care was about 4.8 percent of total care in both years. Public hospitals in big cities increased their free care activities slightly, but this had little impact on the level of care provided in public hospitals overall.

Researchers have offered several explanations for the lack of change in the amount and distribution of charity care between 1980 and 1982. Feder, Hadley, and Mullner [71] suggest that the small group of hospitals that provide the bulk of charity care were not in a financial position to increase their efforts. In companion studies, Hadley and Feder [68,69] and Feder, Hadley, and Mullner [72] found that the kinds of hospitals that provide high levels of care to the poor (i.e., public, teaching, and city hospitals) more often were financially stressed, as evident in Table 9.[21] In addition, Brown [73] and Fine et al. [70] document the decline in governmental support over time for large

Table 9: Hospital Financial Status by Type of Hospital, 1980

Type of Hospital	Percent Distribution by Financial Status*			Total Margin (Percent of Revenues)
	Sound	Shaky	Stressed	
All Hospitals	64.6%	13.1%	22.3%	3.5%
Ownership				
Public	49.0	18.5	32.5	2.1
Private nonprofit	68.6	12.4	19.0	3.6
Proprietary	85.1	3.0	11.8	7.0
Teaching Status				
Nonteaching	63.1	13.2	23.7	3.7
Teaching (non-COTH)	77.8	9.7	12.5	3.4
Teaching (COTH)	59.7	19.3	21.0	1.9
Community Size				
100 largest cities	66.1	12.7	21.2	2.4
Other SMSA†	78.4	11.0	10.5	2.4
Non-SMSA	55.3	14.6	30.1	3.0

Source: Hadley and Feder [68,69].

*As defined by Hadley and Feder [68,69], sound hospitals had surpluses in both service and total operations, shaky hospitals had only service deficits, and stressed hospitals had both service and total deficits.

†Includes suburban areas of the 100 largest cities.

providers of charity care—public and teaching hospitals. Stressed hospitals had to reduce the extent of their free care, typically by discouraging or denying care to nonemergency patients, or by limiting the operations of outpatient clinics. Major charity care hospitals that were in sound condition in 1980, on the other hand, increased their charity care by 1982. The increase from sound hospitals basically balanced out the decline from stressed providers.

Many believe that the distribution of charity care between public and private hospitals is currently undergoing change. The Reagan administration in the past few years has reduced Medicaid funding and has increasingly called on the private sector to take more responsibility for indigent care. However, private philanthropy is not likely to have increased over this period due to changes in the tax provisions for charitable contributions in 1981. In fact, Clotfelter and Salamon [74] estimated that these changes would reduce private contributions to churches, universities, hospitals, service organizations, and other nonprofit institutions by $18 billion between 1981 and 1984.[22] In addition, many have suggested that hospitals use patient revenues generated

from those whose bills are paid to partially offset the costs of uncompensated care. This practice is increasingly being called into question by major third-party payers. Thus, faced with increased cost pressures and a highly competitive market, private hospitals will most likely respond to government cutbacks by limiting rather than increasing charity care.

Hospitals can take several actions to limit charity care but one method in particular, patient transfers, has attracted much attention (Demkovich [75] and Friedman [76]). It is feared that some patients are being transferred in unstable condition and are at risk of complications while in transit. Himmelstein et al. [77] found that nearly 25 percent of all patient transfers from several private hospitals in one geographic area were at risk of adverse effects during the transfer. Of these patients, they estimate that one-third received substandard care due to delay in needed diagnosis or therapy. Another problem they found was that the public hospital to which a patient was transferred often did not have the facilities needed to treat his/her particular condition.

Physicians

Little current data are available on physicians' provision of charity care. However, some limited information does exist on the characteristics of physicians who provide charity care and on those who participate in Medicaid. In addition, information is available on programs that medical societies have established to provide physician care to indigents.

Two studies have examined the characteristics of physicians who provide large amounts of charity care. Culler and Ohsfeldt [64] examined 1982 data from the American Medical Association's Socioeconomic Monitoring System and found that older physicians, those who graduated from foreign medical schools, and those practicing in areas with high unemployment rates provide more care to the disadvantaged. Sloan, Cromwell, and Mitchell [78] in an earlier study found that physicians participating in Medicare and Medicaid and those practicing in rural areas were also more likely to have higher levels of uncompensated care. The latter study also found that bad debts for physicians were over four times larger than losses from reduced fees. This suggests that physicians make decisions to reduce or eliminate charges after the patient has already been billed for services rather than before services are performed.

A number of studies have also considered the characteristics of

physicians participating in the Medicaid program. Characteristics reported in the Economic Report of the President [41] and by Sloan, Cromwell, and Mitchell [78] are very similar to those noted above for uncompensated care. In addition, Garner, Lias, and Sharpe [79] found that general practitioners and family physicians are more likely to participate. Mitchell and Schurman [80] and Sloan, Cromwell, and Mitchell [78] found that physicians in states with more generous Medicaid reimbursement, less restrictive eligibility criteria, and fewer administrative burdens are more willing to participate.

State and local medical societies have also been instrumental in establishing programs that offer free physician care to needy individuals. An AMA newsletter [81] reported examples of such programs that were established during the 1982 recession. For instance, the Arlington County Medical Society of Virginia and the King County Medical Society of Washington established hotline/referral systems to match indigents with county physicians who had agreed to treat them at no charge. The American Medical Association [63] reported that 10 percent of physicians interviewed in a 1982 nationwide survey participated in these types of programs.

SUMMARY

Hospitals and physicians have reported large amounts of uncompensated care. Extensive information is available on hospital provision of uncompensated care and some limited data exist on physicians. Many questions remain unanswered: how many patients seek charity care, what types of services do different hospitals offer them? How do hospitals finance uncompensated care? What impacts do charity care and its financing have on patients and the community? Do the medically indigent delay seeking care until they are more seriously ill? Finally, do they differ from others in their perception of health status? Colorado, North Carolina, and Tennessee [47,60,61] have addressed some of these questions in detailed studies of indigent care within their own states, but currently no answers are available for the entire nation.

THE IMPACT OF STRUCTURAL CHANGES ON INDIGENT CARE

Increased concern over cost containment and a highly competitive hospital market have resulted in several changes in the U.S. health care delivery system. These include:

- Hospital closings and the growth of systems
- Growing specialization of hospital services
- Development of prospective payment systems and preferred provider networks.

Although much speculation exists on the potential impacts of these changes on indigent care, little research has taken place due to the lack of needed data. This section will describe briefly the potential influences of these changes on indigent care.

HOSPITAL CLOSINGS AND THE GROWTH OF SYSTEMS

Economic pressures on hospitals are creating several changes in the hospital sector. Most notably, a substantial number of hospitals in poor financial condition, including 70 public hospitals, have closed in the past few years. In addition, Sager [82] noted a similar trend among urban voluntary hospitals serving minority neighborhoods and large numbers of Medicaid patients. These closings may have a detrimental effect on indigent care, since public hospitals are typically large providers of charity care. Hadley and Feder [83] suggest that closures may also hurt poor neighborhoods through reductions in employment opportunities, which in itself may add to the size of the indigent population in a community.

Some local and state authorities have chosen to transfer management or ownership of public hospitals to hospital chains rather than to close these facilities. Since 1970, 180 public hospitals have been purchased, leased, or managed under contract by multihospital systems [84]. The potential effects of this type of hospital consolidation are mixed. Through transfer, the hospital remains open, thus maintaining employment opportunities in the community and a readily available source of care. Consolidation has also led to the improvement and renovation of some hospitals whose facilities were deteriorating and in need of repair. These tend to improve services in these hospitals to all individuals, including indigent patients. However, the level of charity care may fall at a hospital that was formerly public, since private voluntary and proprietary hospitals historically have provided less of this type of care.

In some instances, the sale of a facility to private operators has led to innovative ways of providing care to the indigent. Tolchin [84] reports that explicit trust funds for indigent care are sometimes established as part of the purchase price. These trust funds, which receive continuing contributions from the state or county and from the hospi-

tal, are used to partially defray the costs of uncompensated care to area indigents. In addition, Humana in Louisville, Kentucky, when it leased the public teaching hospital, opened a satellite clinic in a poor neighborhood to treat patients at a lower cost than in the hospital's emergency room. Thus, the effects of hospital consolidation require careful examination.

The large growth in the for-profit sector has also raised concern about the availability of indigent care. The number of proprietary hospitals increased from 738 to 757 hospitals between 1972 and 1983 [85]. Investor-owned hospitals have also entered into management contracts with many not-for-profit hospitals in recent years: the number of these contracts increased by 155.9 percent between 1976 and 1984. Acquisition or management of private, voluntary hospitals by investor-owned hospital chains may have no effect on the level of charity care since voluntary and for-profit hospitals have historically provided about the same amount of uncompensated care. However, the growing influence of the for-profit sector may affect the level of charity care provided by hospitals owned or managed by proprietary entities.

GROWING SPECIALIZATION OF HOSPITAL SERVICES

Besides changing patterns of ownership and organization, a highly competitive market may lead to the increasing specialization of services offered in particular facilities. Hospitals may seek to eliminate service areas that are highly costly and that thereby reduce overall hospital performance. Cost centers for hospitals tend to be emergency rooms and outpatient departments. In the future, then, many hospitals may provide strictly tertiary care, while a few will offer only primary care.

If specialization is widespread, care for the indigent may be adversely affected. Since indigents rely extensively on emergency and outpatient departments, closure of these departments may severely reduce their access to needed care. Hospitals offering only primary care would then see their indigent caseload increase dramatically. Since primary care hospitals will not have many revenue-generating areas to offset uncompensated costs, they may be forced to place limits on charity care. Therefore, trends in specialization and their influence on charity care must be closely monitored.

DEVELOPMENT OF PROSPECTIVE PAYMENT MECHANISMS AND PREFERRED PROVIDER ORGANIZATIONS

Large increases in health expenditures and insurance premium costs have led third-party payers and private businesses to increase cost-

containment efforts. Two efforts in particular may have detrimental effects on indigent care: (1) prospective payment systems and (2) Preferred Provider Organizations (PPOs).

Prospective payment systems, such as the one developed for Medicare inpatient care, pay hospitals based on diagnosis rather than on costs. Hospitals have typically incorporated into charges some of the costs of uncompensated care. Prospective payment, then, may make it difficult for hospitals to recoup these costs, especially in hospitals serving large numbers of Medicare patients and small numbers of privately insured patients. Recognizing this deficiency in Medicare prospective rates, the Prospective Payment Assessment Commission has recommended that the Medicare payment rates be adjusted to compensate hospitals serving disproportionately large numbers of Medicare and low-income patients [86]. However, these changes are unlikely in the near future.

The establishment of PPOs by private business and insurers places similar pressures on hospitals. Several large employers have negotiated arrangements with health care providers that discount charges for a guaranteed volume of patients. Like prospective payment, these discounts limit the ability of hospitals to shift uncompensated costs to paying patients, which may result in limits on charity care in those hospitals participating in PPOs. The Commonwealth Fund [67] notes that the cost pressures resulting from PPOs may be greatest on teaching hospitals, since they may not be able to lower their prices to be competitive and still cross-subsidize their higher levels of indigent care. Currently, no evidence exists to support or repudiate these conjectures.

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NOTES

1. The vast majority of studies focus on the population under age 65, since the elderly have nearly universal coverage through public Medicare insurance. For those studies that report uninsured statistics for the entire population, estimates have been converted to measure the under-65 population only, to keep data reported across studies comparable.
2. Later waves of the National Medical Care Expenditure Survey had

lower estimates for the proportion of the population that is uninsured when compared to the first wave of data reported in Table 1 [2]. Thus, the first-round estimate reported in Table 1 may not be entirely representative of the proportion who were uninsured in that year.

3. In relation to the elderly population, the House Select Committee on Aging [9] projected that the average person over age 65 spent 14.6 percent of his/her income on personal health care in 1984 and will spend 18.9 percent in 1990. Thus, the problem of limited coverage for the elderly may be particularly acute.
4. Farley's definition of underinsurance could potentially be used to estimate the number of Medicaid recipients at risk of being inadequately covered since extensive data on limitations on Medicaid coverage are available. To date, however, no one has applied Farley's definition of underinsurance to the Medicaid population.
5. This figure is estimated from numbers reported in the Robert Wood Johnson Foundation report [6].
6. A U.S. Department of Labor [12] survey of employee benefits in firms with a minimum of 50–250 workers found that all but very few firms (less than .5 percent) offered health insurance covering at least hospital expenses.
7. This estimate is a rough approximation since studies have defined poor and near-poor slightly differently. The estimate is based on data reported in Table 2, which come from Swartz [5], and from data reported in Farley [4] and from the Robert Wood Johnson Foundation [6].
8. This section will focus on those programs that were designed to benefit the population under age 65, since this was the relevant population that was discussed in the prior section. Thus, programs like Medicare, which clearly assist many disadvantaged elderly individuals, will not be examined.
9. Data from this section come from the U.S. Department of Health and Human Services [25] and the U.S. Health Care Financing Administration [26], unless otherwise noted.
10. Data on the federal level are available for 1984, but are not reported here since they are not entirely comparable with the 1982 information.
11. Some states do not report "State-Only" Medicaid expenditures.
12. Patient self-selection into the EPSDT program is a major shortcoming of these studies. As a result, differences in costs and health outcomes may be attributable in part to differences in factors that explain why some participate and others do not, rather than to the EPSDT program itself.
13. This particular report provides a thorough review of the history of Hill-Burton and its effects on the distribution of care.
14. This figure includes charity care provided in excess of Hill-Burton obligations.
15. Cited from *Modern Healthcare* [51].
16. The IHPP data do not clearly distinguish the "State-Only" Medicaid program from the other types.
17. The list of programs reported in Table 7 is incomplete since some states with these programs did not report them.
18. Connecticut, unlike the other states listed, opened its plan to all state residents, not just those with high risk.

19. Lewin and Lewin [56] report that 40 states have this type of legislation.
20. Calculated from the American Medical Association [63], Culler and Ohsfeldt [64], Eiler [65], and Reynolds and Abram [66].
21. However, Hadley and Feder [73] note that provision of indigent care in and of itself is an insufficient explanation for financial stress in hospitals. A combination of indigent care, a high number of Medicaid/Medicare patients, and few commercially insured patients is typically the cause of financial problems in hospitals.
22. Cited from the American Hospital Association [48, p. 25].

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